Outpatient Facility Coding Alert

CPT® Coding: Note These 3 NCCI Exceptions Involving Extensive Shoulder Debridement

Streamline the billing and reimbursement process by following these rules.

Most coders will attest that coding arthroscopic surgeries of the shoulder is a process that takes time to get down pat. Coding different degrees of superior labral tear from anterior to posterior (SLAP) lesion repairs or shoulder synovectomies, for example, can be time-consuming and tedious.

If it's not challenging enough on its own, you've also got to consider what the National Correct Coding Initiative (NCCI) Policy Manual has to say on the subject. As you'll see, you've got to be particularly careful coding arthroscopic debridement alongside a separate shoulder arthroscopic procedure.

Take note of these code-specific guidelines and three important exceptions to the rule of coding shoulder arthroscopies with debridement.

Tackle NCCI Policies Head-On

You should first know that, outside of the knee and shoulder, arthroscopic surgeries always include arthroscopic debridement of the same joint. Chapter 4 of the NCCI Policy Manual states the following:

- "With the exception of the knee and shoulder, arthroscopic debridement shall not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter."

The NCCI Policy Manual goes on to advise coders on how to address arthroscopic surgeries of the shoulder and knee joints that also involve arthroscopic debridement. In this article, the focus turns toward arthroscopic surgeries of the shoulder:

- "Shoulder arthroscopy procedures include limited debridement (e.g., CPT® code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT® code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure."

Factor in This Expert Advice

Refresher: Before making any coding considerations, you want to have a firm understanding of what qualifies as an extensive debridement.

"There is a very fine line as to what constitutes true extensive debridement," says **Tammy Gentry, CPC**, medical coding specialist at Duke University Health System in Durham, North Carolina. "The documentation of just a 'clean up' does not qualify as an extensive debridement," Gentry explains.

Generally, the rule of two or more soft tissues applies to coding debridement procedures. If the provider debrides two or more soft tissues (biceps tendon, labrum, bursae, etc.), then you may consider code 29823 (Arthroscopy, shoulder, surgical; debridement, extensive). However, **Ella King CPC, CPMA, ST**, compliance analyst at Duke University Health System in Durham, North Carolina, further explains that each clinical scenario is different when it comes to coding debridement.

"Coders must evaluate the extent of work done to determine the level of debridement," explains King. "If the report documents labral and/or bone debridement, for example, you may consider code 29823. However, if there is only minimal removal of tissue, then do not include a debridement code," King relays.

There are a couple of points to unpack within the NCCI guidelines listed above. First, limited debridement is always included in shoulder arthroscopic procedures, with no exceptions. This remains the case despite the fact that the limited debridement may be performed in a separate area of the same shoulder.

Second, there are three exceptions to the rule where it's considered appropriate to code extensive debridement alongside the underlying arthroscopic procedure. In all other instances, you should not code extensive debridement with the primary arthroscopic procedure. NCCI lists the following codes as the three exceptions to when you may bill an arthroscopic debridement procedure in addition to an underlying arthroscopic surgery:

- 29824 - Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
- 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair
- 29828 - Arthroscopy, shoulder, surgical; biceps tenodesis.

Furthermore, with these three exceptions, NCCI only allows you to submit 29823 alongside each of these primary procedure codes with an appropriate overriding modifier attached; i.e., modifier 59 (Distinct procedural service). However, before immediately abiding by these guidelines, there's one final point to consider. NCCI states that you may only report 29823 with these codes "if the extensive debridement is performed in a different area of the same shoulder."

With this advice in mind, you still must consider the NCCI guidelines before reporting 29823 with certain surgical procedures. For example, if your provider performs a 29807 (Arthroscopy, shoulder, surgical; repair of SLAP lesion) with extensive labral debridement, billing separately for the debridement is not allowed since it does not fall under the three listed exceptions.

Use Discretion, Payer Guidance When Distinguishing Shoulder Sites

Unfortunately, NCCI doesn't elaborate as to what qualifies as a "different area" of the shoulder. If you are coding a surgical procedure that falls under one of the three exceptions, you may have a difficult time deciding on when it's appropriate to report 29823 in addition to codes 29824, 29827, and 29828. You can consider different sites of the shoulder through one of two contexts.

The first is by viewing the shoulder through the posterior and the anterior portal. For instance, the provider may begin a rotator cuff repair in the anterior portal. The provider may then access the posterior portal to finish debridement of the rotator cuff. In this case, the separate portals may be enough for some payers to consider the posterior portal debridement separate.

You may also consider a separate site as any separate component within the shoulder, regardless of whether the anterior or posterior portals overlap. For example, if the provider performs a rotator cuff repair and proceeds to debride the glenoid labrum, you may consider reporting and billing for both services. However, depending on the clinical scenario, you may want to refer back to the "rule of two" when it comes to determining whether reporting code 29823 is appropriate.